91-1197

Case No. _____

Supreme Court, U.S.
FILED
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BEFORE THE

SUPREME COURT OF THE UNITED STATES

OCTOBER 1991 TERM

WESTCHESTER MANAGEMENT CORP.
dba SALEM PARK NURSING HOME
11223 Cornell Park Drive
Cincinnati, Ohio 45242,

Petitioner,

v.

UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES
200 Independence Avenue
Washington, D.C. 20201,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTION PRESENTED FOR REVIEW

NO TEN THOUSAND DOLLAR AMOUNT IN CONTROVERSY REQUIREMENT IS ESTABLISHED BY FEDERAL LAW (42 U.S.C. §§ 405(h), 1395oo(f)(1)) TO PREVENT A MEDICARE PROVIDER FROM ASSERTING CLAIMS OF CONSTITUTIONAL AND STATUTORY VIOLATIONS IN THE FAILURE OF A FEDERAL AGENCY TO PROPERLY PROMULGATE STANDARDS AS RULES BEFORE APPLYING THOSE STANDARDS TO THE HARM OF THE PROVIDER.

LISTING OF PARTIES

Westchester Management Corporation[1]
dba Salem Park Nursing Home
11223 Cornell Park Drive
Cincinnati, Ohio 45242

Petitioner

The United States Department of Health and Human Services
200 Independence Avenue
Washington, D.C. 20201

Respondent

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[1] Westchester Management Corporation is a wholly owned subsidiary of Parke Care Centers, Inc., an Ohio corporation.

TABLE OF CONTENTS

Page

QUESTION PRESENTED FOR REVIEW I

NO TEN THOUSAND DOLLAR AMOUNT IN CONTROVERSY REQUIREMENT IS ESTABLISHED BY FEDERAL LAW (42 U.S.C. §§ 405 (h), 1395oo(f)(1)) TO PREVENT A MEDICARE PROVIDER FROM ASSERTING CLAIMS OF CONSTITUTIONAL AND STATUTORY VIOLATIONS IN THE FAILURE OF A FEDERAL AGENCY TO PROPERLY PROMULGATE STANDARDS AS RULES BEFORE APPLYING THOSE STANDARDS TO THE HARM OF THE PROVIDER.

Listing of Parties II

Table of Contents III

Table of Authorities VI

Jurisdictional Statement 1

Involved Constitutional Provisions 2

Involved Statutory Provisions 2

Statement of the Case and Facts 9

PRM-1, Section 1011.2 ..... 9, 10

28 U.S.C. Section 1331 10

28 U.S.C. Section 1346 10

Due Process Clause, Fourteenth Amendment to the United States Constitution 10

42 U.S.C. Section 1395x(v)(1)(A) 10

5 U.S.C. Section 553(B) 10

42 U.S.C. Section 405(h) 10

Page

42 U.S.C. Section 1395ii 10

42 U.S.C. Section 1395oo(f)(1) 10, 11

Heckler v. *Ringer*,
466 U.S. 602, 615 (1984) 11

Weinberger v. *Salfi*,
422 U.S. 749, 762 (1975) 11

Bowen v. *Michigan Academy of Family Physicians*,
476 U.S. 667 (1986) 11

Argument in Support of Allowance of Writ 12

Bowen v. *Michigan Academy of Family Physicians*,
476 U.S. 667, 672, 675, 678, 680, 681, 106 S. Ct.
2137, 2138, 2140, 2141 (1986) 12, 14, 15, 17, 18, 19

42 U.S.C. Section 405(h) 12, 13, 14, 17

42 U.S.C. Section 1395oo(f)(1) 12, 13, 16

42 U.S.C. Section 1395oo(f) 12

H.P. Rep. No. 96-1167, reprinted in 1980 U.S. Code
Cong. & Ad. News 5757 13

Abbott Laboratories v. *Gardner*,
387 U.S. 136 (1967) 14

Nat. Assn. of Psy. Treatment Ctrs. v. *Weinberger*,
658 F. Supp. 48, 51 (D. Colo. 1987) 14

McNary v. *Haitian Refugee Center, Inc.*,
111 S. Ct. 888 (1991) 15

Memorial Hospital v. *Heckler*,
706 F. 2d 1130, 1133 (11th Cir. 1983) 16

Beverly Hospital v. *Bowen*,
872 F. 2d 483, 486 (D.C. Cir. 1989) 16

Weinberger v. Salfi,
422 U.S. 749, 762 (1975) 17, 18

Page

Heckler v. *Ringer*,
466 U.S. 602, 615 (1984) 17, 18

Block v. *Community Nutrition Institute*,
467 U.S. 340, 350, 351 (1984) 19

APPENDIX

November 5, 1991, Judgment Entry of the United States Court of Appeals for the Sixth Circuit 1a

November 5, 1991, Opinion of the United States Court of Appeals for the Sixth Circuit 2a

January 29, 1991, Dismissal Order of the United States District Court, Southern District of Ohio, Western Division 10a

June 5, 1990, Health Care Financing Administrative Review Decision 15a

Medicare Provider Appeal Decision of Blue Cross and Blue Shield Association 17a

Medicare Provider Reimbursement Manual Instruction, Section 1011.2 of HCFA Pub. 15-1 ..... 23a

Petitioner's Complaint 23a

TABLE OF AUTHORITIES

Cases Page

Abbott Laboratories v. *Gardner*,
387 U.S. 136 (1967) 14

Beverly Hospital v. *Bowen*,
872 F. 2d 483, 486 (D.C. Cir. 1989) 16

Block v. *Community Nutrition Institute*,
467 U.S. 340, 350, 351 (1984) 19

Bowen v. *Michigan Academy of Family Physicians*,
476 U.S. 667, 672, 675, 678, 680, 681, 106 S. Ct.
2137, 2138, 2140, 2141 (1986) . . 11, 12, 14, 15, 17, 18, 19

Heckler v. *Ringer*,
466 U.S. 602, 615 (1984) 11, 17, 18

McNary v. *Haitian Refugee Center, Inc.*,
111 S. Ct. 888 (1991) 15

Memorial Hospital v. *Heckler*,
706 F. 2d 1130, 1133 (11th Cir. 1983) 16

Nat. Assn. of Psy. Treatment Ctrs. v. *Weinberger*,
658 F. Supp. 48, 51 (D. Colo. 1987) 14

Weinberger v. Salfi,
422 U.S. 749, 762 (1975) 11, 17, 18

Constitutional Provisions

Due Process Clause, Fourteenth Amendment to the
United States Constitution 10

Statutes

5 U.S.C. Section 553(b) 10

28 U.S.C. Section 1331 10

Page

28 U.S.C. Section 1346 10

42 U.S.C. Section 405(h) 10, 12, 13, 14, 17

42 U.S.C. Section 1395ii 10

42 U.S.C. Section 1395oo(f)(1) 10, 11, 12, 13, 16

42 U.S.C. Section 1395x(v)(1)(A) 10

Other Authorities

H.R. Rep. No. 96-1167, reprinted in 1980 U.S. Code Cong. & Ad. News 5757 13

PRM-1, Section 1011.2 ..... 9, 10

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PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

JURISDICTIONAL STATEMENT

Petitioner Westchester Management Corporation dba Salem Park Nursing Home invokes the jurisdiction of the United States Supreme Court to grant a writ of certiorari for the review of a November 5, 1991, final judgment of the United States Court of Appeals for the Sixth Circuit. Petitioner submits in light of its timely filing under United States Supreme Court Rule 13 of the instant petition for writ of certiorari, 28 U.S.C. Section 1254(1) confers upon the United

States Supreme Court jurisdiction to review this judgment of the United States Court of Appeals for the Sixth Circuit by writ of certiorari.

INVOLVED CONSTITUTONAL PROVISIONS

Fourteenth Amendment to the United States Constitution, Due Process Clause

> No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

INVOLVED STATUTORY PROVISIONS

28 U.S.C. § 1331

The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States. As amended July 25, 1958, Pub.L. 85-554, § 1, 72 Stat. 415; Oct. 21, 1976, Pub.L. 94-574, § 2, 90 Stat. 2721; Dec. 1, 1980, Pub.L. 96-486, § 2(a), 94 Stat. 2369.

28 U.S.C. § 1346

(a) The district courts shall have original jurisdiction, concurrent with the United States Claims Court, of:

(1) Any civil action against the United States for the recovery of any internal-revenue tax alleged to have been erroneously or illegally assessed or collected, or any penalty claimed to have been collected without authority or any sum alleged to have been excessive or in any manner wrongfully collected under the internal-revenue laws;

(2) Any other civil action or claim against the United States, not exceeding $10,000 in amount, founded either upon

the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort, except that the district courts shall not have jurisdiction of any civil action or claim against the United States founded upon any express or implied contract with the United States or for liquidated or unliquidated damages in cases not sounding in tort which are subject to sections 8(g)(1) and 10(a)(1) of the Contract Disputes Act of 1978. For the purpose of this paragraph, an express or implied contract with the Army and Air Force Exchange Service, Navy Exchanges, Marine Corps Exchanges, Coast Guard Exchanges, or Exchange Councils of the National Aeronautics and Space Administration shall be considered an express or implied contract with the United States.

(b) Subject to the provisions of chapter 171 of this title, the district courts, together with the United States District Court for the District of the Canal Zone and the District Court of the Virgin Islands, shall have exclusive jurisdiction of civil actions on claims against the United States, for money damages, accruing on and after January 1, 1945, for injury or loss of property, or personal injury or death caused by the negligent or wrongful act or omission of any employee of the government while acting within the scope of his office or employment, under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred.

(c) The jurisdiction conferred by this section includes jurisdiction of any set-off, counterclaim, or other claim or demand whatever on the part of the United States against any plaintiff commencing an action under this section.

(d) The district courts shall not have jurisdiction under this section of any civil action or claim for a pension.

(e) The district courts shall have original jurisdiction of any civil action against the United States provided in section

6226, 6228(a), 7426, or 7428 (in the case of the United States district court for the District of Columbia) or section 7429 of the Internal Revenue Code of 1954.

(f) The district courts shall have exclusive original jurisdiction of civil actions under section 2409a to quiet title to an estate or interest in real property in which an interest is claimed by the United States. As amended Apr. 25, 1949, c. 92, § 2(a), 63 Stat. 62; May 24, 1949, c. 139, § 80(a, b), 63 Stat. 101; Oct. 32, 1951, c. 655, § 50(b), 65 Stat. 727; July 30, 1954, c. 648, § 1, 68 Stat. 589; July 7, 1958, Pub.L. 85-508, § 12(e), 72 Stat. 348; Aug. 30, 1964, Pub.L. 88-519, 78 Stat. 699; Nov. 2, 1966, Pub.L. 89-719, Title II, § 202(a), 80 Stat. 1148; July 23, 1970, Pub.L. 91-350, 84 Stat. 449; Oct. 25, 1972, Pub.L. 92-562, § 1, 86 Stat. 1176; Oct. 4, 1976, Pub.L. 94-455, Title XII, § 1204(c)(1), Title XIII, § 1306(b)(7), 90 Stat. 1697, 1719; Nov. 1, 1978 Pub.L. 95-563, § 14(a), 92 Stat. 2389; Apr. 2, 1982, Pub.L. 97-164, Title I, § 129, 96 Stat. 39; Sept. 3, 1982, Pub.L. 97-248, Title IV, § 402(c)(17), 96 Stat. 669.

42 U.S.C. § 405(h)

The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 1395oo(f)(1)

A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the

Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final deciaion and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5, notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must

be brought by such providers as a group with respect to any matter involving an issue common to such providers.

42 U.S.C. § 1395ii

The provisions of sections 406 and 416(j) of this title, and of subsections (a), (d), (e), (h), (i), (j), (k) and (l) of Section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter. (As amended July 18, 1984, Pub. L. 98-369, Title III, § 2354(b)(36), 98 Stat. 1102).

42 U.S.C. § 1395x(v)(1)(A)

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items of services, may provide for the establishment of limits on the direct or indirect overall incurred costs of incurred costs of specific items of ser-

vices or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges of a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by this insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

5 U.S.C. § 553(b)

General notice of proposed rulemaking shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include:

(1) A statement of the time, place, and nature of public rulemaking proceedings:

(2) Reference to the legal authority under which the rule is proposed; and

(3) Either the terms or substance of the proposed rule of a description of the subjects and issues involved.

Except when notice or hearing is required by statute, this subsection does not apply —

(A) To interpretative rules, general statements of policy, or rules of agency organization, procedure or practice; or

(B) When the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure therein are impracticable, unnecessary, or contrary to the public interest.

STATEMENT OF CASE AND FACTS

Petitioner Westchester Management Corporation dba Salem Park Nursing Home ("Petitioner") owns and operates a one hundred seven bed skilled care nursing facility which participates as a Part A provider in the Medicare Program. During 1984, Petitioner, pursuant to a lease entered into on January 1, 1977, leased the nursing home operation from Suburban Nursing and Mobile Homes, Inc. ("Suburban"). Prior to December 1982, Parke Care Centers, Inc. purchased all issued and outstanding shares of Petitioner and the assets of Petitioner (including the lease agreement) from Suburban.

The lease was not renegotiated by Parke Care Centers, Inc. due to the low rental rate and favorable terms of the lease agreement. Petitioner and Petitioner's parent corporation are independent free-standing corporations with no control or common ownership in or emanating from, to, or with Suburban. At the time of Petitioner's current stockholders' purchase of Petitioner's stock there was no regulation or policy of the Health Care Financing Administration of the U.S. Department of Health and Human Services ("HCFA") mandating the continuation of related party status for a non-related party purchaser which continued to pay rent under a lease agreement previously entered into by related parties.

In December, 1982, HCFA created Section 1011.2 of the Provider Reimbursement Manual for long-term care providers by mailing it to Intermediaries. The language of this manual section provides if a lease agreement is considered a product of a related party transaction at its inception, it retains this related party status for its entire term, regardless whether the parties to this agreement change. Through the present date the contents of Section 1011.2 of the Manual for long-term care providers have never been promulgated as a rule pursuant to the Administrative Procedure Act.

Community Mutual Insurance Company ("CMI"), as the Ohio Intermediary on behalf of HCFA, issued an audit report for Salem Park Nursing Home for 1984. This report set forth a

number of proposed adjustments including an adjustment disallowing lease payments based upon a finding of a related party relationship between Petitioner and Suburban. Petitioner appealed this and other findings.

At a hearing before the Blue Cross and Blue Shield Association, Petitioner challenged the validity of this related party instruction (PRM-1, Section 1011.2) on constitutional and statutory grounds. After Petitioner's challenge was rejected due to the lack of authority to disobey an instruction of HCFA, Petitioner appealed this decision to the Secretary. Upon the Secretary's confirmation of the hearing officer's lack of authority to hear the issue, Petitioner commenced an action in the United States District Court, Southern District of Ohio, Western Division against the United States Department of Health and Human Services (hereinafter "Respondent").

Petitioner set forth claims for relief based upon subject matter jurisdiction granted by 28 U.S.C. §§ 1331 and 1346. Petitioner challenged the constitutionality of the Secretary's use of the Provider Reimbursement Manual § 1011.2. Petitioner requested the Trial Court to declare this instruction of the Secretary to violate the Due Process Clause of the Fourteenth Amendment to the United States Constitution, 42 U.S.C. § 1395x(v)(1)(A) and 5 U.S.C. § 553(b).

Respondent filed a motion to dismiss for lack of subject matter jurisdiction. The District Court issued an order (on January 29, 1991) granting the motion. The District Court found "42 U.S.C. Section 405(h) and 42 U.S.C. Section 1395ii specifically denies [sic] federal jurisdiction under 28 U.S.C. Section 1331 or 28 U.S.C. Section 1346 for claims arising under the Medicare Act." The District Court also ruled it did not have subject matter jurisdiction pursuant to 42 U.S.C. Section 1395oo(f)(1) because the amount in controversy per Petitioner's complaint was less than ten thousand dollars. The District Court stated "the inquiry in determining whether Section 405(h) bars federal-question jurisdiction must be whether the claim 'arises under' the Act, not whether it lends

itself to a 'substantive' rather than a 'procedural' label." The Court relied upon its construction of *Heckler* v. *Ringer*, 466 U.S. 602, 615 (1984), and *Weinberger* v. *Salfi*, 422 U.S. 749, 762 (1975).

On February 11, 1991, Petitioner filed with the United States District Court, Southern District of Ohio, Western Division, a notice of appeal to the United States Court of Appeals for the Sixth Circuit.

The Court of Appeals affirmed this dismissal order of the Trial Court by finding the ten thousand dollar threshold of 42 U.S.C. § 1395oo(f)(1) precluded judicial review of Petitioner's constitutional and statutory challenge to the Secretary's Medicare manual instruction. The court found that *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), did not apply to a constitutional and statutory challenge made by a Part A Medicare Provider to an instruction or regulation of the Secretary. The Court of Appeals found the case of *Bowen* v. *Michigan Academy of Family Physicians*, *supra*, applied to constitutional and statutory challenges which were made by Medicare Part B claimants without a forum to present a claim against the Secretary. Petitioner seeks the United States Supreme Court review of this November 5, 1991, final ruling of the United States Court of Appeals for the Sixth Circuit.

ARGUMENT IN SUPPORT OF ALLOWANCE OF WRIT

The Court of Appeals opinion has decided an important question of federal law — whether only a Part A Medicare Provider which has a claim in controversy greater than ten thousand dollars (or Part A Medicare Providers who have combined claims greater than fifty thousand dollars) has available judicial review to challenge an instruction or regulation of the United States Department of Health and Human Services. The Court of Appeals construed the United States Supreme Court's ruling in *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), supports their decision in this action restricting access to judicial review.

However, the decision in *Bowen* v. *Michigan Academy of Family Physicians*, *supra*, speaks only of judicial review of Medicare Part B claimants statutory or constitutional challenges to an instruction or regulation of the United States Department of Health and Human Services. This Court has not decided that 42 U.S.C. Sections 405(h), and 1395oo(f)(1) precludes a Part A Medicare Provider with an injury less than ten thousand dollars (or Providers with combined, related claims not exceeding fifty thousand dollars) from asserting statutory and constitutional challenges to an instruction or a regulation of the United States Department of Health and Human Services.

Petitioner submits the Court of Appeals' constuction of *Bowen* v. *Michigan Academy of Family Physicians*, *supra*, is inconsistent with the rationale utilized by the United States Supreme Court in *Bowen* v. *Michigan Academy of Family Physicians*, *supra*, and other precedent of the United States Supreme Court.

42 U.S.C. Section 1395oo(f)(1) does provide a Provider the right to seek review before a United States District Court of "any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy." Congress amended 42 U.S.C. Section 1395oo(f) to include this provision to ensure there would not be unnecessary

delay in review of statutory and constitutional challenges brought by qualifying Medicare Part A Providers:

> Under present law, a provider's dissatisfaction with a particular determination made by its fiscal intermediary on the basis of a regulation issued by the Secretary must first be brought to the Board, even though the Board may not have the authority to reverse or overrule the regulation. (The Board has no authority, for example, to rule on the legality of the Secretary's regulations but it must, nonetheless, conduct a full review of the challenge). The effect of this process has been to delay the resolution of controversies for extended periods of time and to require providers to pursue a time-consuming and irrelevant administrative review merely to have the right to bring suit in a U.S. District Court. Title VIII addresses this problem by giving medicare providers the right to obtain immediate judicial review in instances where the Board determines that it lacks jurisdiction to grant the relief sought.
>
> H.R. Rep. No. 96-1167, reprinted in 1980 U.S. Code Cong. & Ad. News 5757.

The Court of Appeals opinion interprets 42 U.S.C. Section 1395oo(f)(1) to restrict the avenue of judicial review statutory and constitutional challenges to Medicare Part A Providers which meet an amount in controversy requirement. Through this narrow construction of 42 U.S.C. Section 1395oo(f)(1) the Court of Appeals found 42 U.S.C. Section 405(h) precluded the District Court from exercising subject matter jurisdiction over Petitioner's constitutional and statutory challenge to a manual instruction of HCFA.

The Sixth Circuit's restrictive construction of 42 U.S.C. Section 1395oo(f)(1) runs counter to the strong presumption in favor of judicial review. Parties aggrieved by agency action are entitled to judicial review "unless there is persuasive

reason to believe that such is the purpose of Congress." *Abbott Laboratories* v. *Gardner*, 387 U.S. 136 (1967). As a result, this strong presumption may only be overcome by a clear showing of explicit or implicit congressional intent to preclude review. See *Nat. Assn. of Psy. Treatment Ctrs.* v. *Weinberger*, 658 F. Supp. 48, 51 (D. Colo. 1987).

Consistent with its holding in *Abbott Laboratories* v. *Gardner*, *supra*, the United States Supreme Court ruled in *Bowen* v. *Michigan Academy of Family Physicians*, *supra*, the jurisdictional bar of 42 U.S.C. Section 405(h) only applies to challenges to Medicare Part B claim determinations:

> The reticulated statutory scheme, which carefully details the forum and limits of review of "any determination . . . of . . . the amount of benefits under part A," 42 U.S.C. Section 1395ff(b)(1)(C) (1982 ed., Supp. II), and of the "amount of . . . payment" of benefits under Part B, 42 U.S.C. Section 1395u(b)(3)(C), simply *does not speak to challenges mounted against the method by which such amounts are to be determined rather than the determinations themselves.*
>
> * * *
>
> In the face of this persuasive evidence of legislative intent, *we will not indulge the Government's assumption that Congress contemplated review by carriers of "trivial" monetary claims, ibid., but intended no review at all of substantial statutory and constitutional challenges to the Secretary's administration of Part B of the Medicare program.*" This is an extreme position, and one we would be most reluctant to adopt without "a showing of 'clear and convincing evidence,' " *Abbott Laboratories* v. *Gardner*, 387 U.S., at 141, 87 S. Ct., at 1511, to overcome the "strong presumption that Congress did not mean to prohibit all judicial review" of executive action, *Dunlop* v. *Bachowski*, 421 U.S., at 567.

> *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. *supra*, at 675, 680 and 681, 106 S. Ct. *supra*, at 2138, 2141. (emphasis added) (footnote omitted)

The United States Supreme Court in *Bowen* v. *Michigan Academy of Family Physicians*, *supra*, further explained this ruling by finding challenges to instructions or regulations of the Secretary of the United States Department of Health and Human Services were not delegated to private carriers:

> Careful analysis of the governing statutory provisions and their legislative history this reveals that Congress intended to bar judicial review only of determinations of the amount of benefits to be awarded under Part B. Congress delegated this task to carriers who would finally determine such matters in conformity with the regulations and instructions of the Secretary. *We conclude, therefore, that those matters which Congress did not leave to be determined in a "fair hearing" conducted by the carrier — including challenges to the validity of the Secretary's instructions and regulations* — are not impliedly insulated from judicial review by 42 U.S.C. § 1395ff (1982 ed. and Supp. II).
>
> * * *
>
> By the same token, matters which Congress did *not* delegate to private carriers, *such as challenges to the validity of the Secretary's instructions and regulations, are cognizable in courts of law.*
>
> *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. *supra*, at 678 and 680, 106 S. Ct., *supra*, at 2140, 2141. (emphasis added)

This Court affirmed this crucial distinction most recently in *McNary* v. *Haitian Refugee Center, Inc.*, 111 S. Ct. 888 (1991).

The Sixth Circuit's ruling will allow a significant violation of rights to occur with no forum for relief. So long as the

harm is, economically, less than ten thousand dollars, a provider has *no* forum.

This ruling of the Sixth Circuit improperly violates the presumption in favor of judicial review. Neither the contents nor the legislative history of 42 U.S.C. Section 1395oo(f)(1) demonstrate any intent by Congress to preclude judicial review for constitutional and statutory challenges of this type of Medicare Part A Provider. Nevertheless, the Sixth Circuit construes 42 U.S.C. Section 1395oo(f)(1)'s expedited legal review (available to only some Part A Providers) to eliminate all other Part A Providers' access to judicial review.

> To expand the non-reviewability of intermediary decisions to include policy decisions of the Secretary would not merely insulate from judicial scrutiny the finding of an intermediary. It would give the Secretary virtually unbridled discretion to prevent reimbursement through regulations. Such a result would run contrary to the presumption favoring judicial review. See *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 141, 87 S. Ct. 1507, 1511, 18 L. Ed. 2d 681 (1967) ("[O]nly upon a showing of 'clear and convincing evidence' of a contrary legislative intent should the courts restrict access to judicial review."); *Deering Milliken, Inc.* v. *Occupational Safety and Health Review Comm.*, 630 F. 2d 1094, 1099 (5th Cir. 1980).
>
> *Memorial Hospital* v. *Heckler*, 706 F. 2d 1130, 1133 (11th Cir. 1983).

The more reasoned and better opinion is the Court of Appeals for the District of Columbia which holds:

> The 42 U.S.C. § 1395oo route is indeed exclusive when it is genuinely available to provide redress; when that is not the case, however, parties may invoke general federal question jurisdiction, 28 U.S.C. § 1331 (1982) . . . .
>
> *Beverly Hospital* v. *Bowen*, 872 F. 2d 483, 486 (D.C. Cir. 1989).

Further there is simply no language contained in the legislative history of Congress' 1980 amendment to 42 U.S.C. Section 1395oo(f)(1) which reflects an intent to preclude judicial review over a subclass of Medicare Part A Providers. If Congress truly had concerns over a potential flood of constitutional/statutory litigation on the operation of Part A of the Medicare program, Congress would have expressed such intent to limit judicial review over this type of action.

Petitioner submits the Court of Appeals has selectively construed previous United States Supreme Court precedent of *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), and *Heckler* v. *Ringer*, 466 U.S. 602 (1984), to implement an unduly narrow construction of *Bowen* v. *Michigan Academy of Family Physicians*, *supra*. The Sixth Circuit relied upon *Weinberger* v. *Salfi*, *supra*, and *Heckler* v. *Ringer*, *supra*, to reach its conclusion 42 U.S.C. Section 405(h) precludes federal court subject matter jurisdiction over Petitioner's constitutional and statutory challenge to a Medicare manual instruction. However, the United States Supreme Court in *Bowen* v. *Michigan Academy of Family Physicians* rejected such a narrow construction of *Weinberger* v. *Salfi* and *Heckler* v. *Ringer*:

* * *

> The Government contends that the third sentence of § 405(h) by its terms prevents any resort to the grant of general federal question jurisdiction contained in 28 U.S.C. § 1331. It finds support for this construction in *Weinberger* v. *Salfi*, 422 U.S. 749, 756-762 (1975), and *Heckler* v. *Ringer*, 466 U.S. 602, 614-616, 620-626 (1984). Respondents counter that the dispositions in these two cases are consistent with the view that Congress' purpose was to make clear that, whatever specific procedures it provided for judicial review of final action by the Secretary were exclusive, and could not be circumvented by resort to the general jurisdiction of the federal courts. Cf. *Weinberger* v. *Salfi*, 422 U.S. at 764-765; *Heckler* v. *Ringer*, 466 U.S., at 621-622.

> Whichever may be the better reading of *Salfi* and *Ringer*, we need not pass on the meaning of Section 405(h) in the abstract to resolve this case. Section 405(h) does not apply on its own terms to Part B of the Medicare program, but is instead incorporated *mutatis mutandis* by Section 1395ii. The legislative history of both the statute establishing the Medicare program and the 1972 amendments thereto provides specific evidence of Congress' intent to foreclose review only of "amount determinations" — i.e., those "quite minor matters," 118 Cong. Rec. 33992 (1972) (remarks of Sen. Bennett), remitted finally and exclusively to adjudication by private insurance carriers in a "fair hearing."
>
> * * *
>
> *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S., *supra*, at 679, 680, 106 S. Ct., *supra*, at 2140, 2141 (footnotes omitted)

It is necessary that the United States Supreme Court address the Sixth Circuit's restrictive incorporation of these holdings into the Medicare Part A program. Otherwise, the required showing of clear and convincing evidence of Congressional intent for the prohibition of judicial review of executive action will be allowed to be dramatically and dangerously compromised. The United States Supreme Court most recently in *Bowen* v. *Michigan Academy of Family Physicians*, *supra*, rejected an overly broad application of the clear and convincing evidence standard for the determination of Congressional intent for judicial review:

> Of course, this court has "never applied the 'clear and convincing' evidence standard in the strict evidentiary sense;" nevertheless the standard serves as "a useful reminder to courts that, where substantial doubt about the congressional intent exists, the general presumption favoring judicial review of administrative action is controlling."

Bowen v. *Michigan Academy of Family Physicians*, 476 U.S., *supra*, at 672, 106 S. Ct., *supra*, at 2137, fn3, citing *Block* v. *Community Nutrition Institute*, 467 U.S. 340, 350, 351 (1984).

Alexander Hamilton, in the Federalist Papers, No. 80, writes: "And the responsibility for an injury ought ever to be accompanied with the faculty of preventing it." Here an injury has occurred, constitutional rights have been denied and will continue to be denied, so long as done in small increments there is no faculty to prevent it. The small, piecemeal loss of rights is no less egregious than the wholesale aggrandizement of rights.

The United States Court of Appeals for the Sixth Circuit's overly broad application in the instant case of this evidentiary standard for the determination of the right to judicial review should similarly be rejected.

Respectfully submitted,

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APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No: 91-3162

WESTCHESTER MANAGEMENT CORPORATION,
d/b/a Salem Park Nursing Home,
Plaintiff-Appellant,

v.

UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES,
Defendant-Appellee.

Before: Martin and Jones, Circuit Judges;
Brown, Senior Circuit Judge

JUDGMENT
(Filed November 5, 1991)

ON APPEAL from the United States District Court for the Southern District of Ohio at Cincinnati.

THIS CAUSE was heard on the record from the district court and was argued by counsel.

ON CONSIDERATION WHEREOF, it is ordered that the judgment of the district court is affirmed.

ENTERED BY ORDER OF THE COURT
/s/ LEONARD GREEN,
Clerk

Issued as Mandate: November 27, 1991

COSTS: None

Filing Fee.....$
Printing .....$

Total .....$

[CERTIFICATION OMITTED]

RECOMMENDED FOR FULL TEXT PUBLICATION
Pursuant to Sixth Circuit Rule 24

No. 91-3162

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

WESTCHESTER MANAGEMENT CORPORATION, d/b/a Salem Park Nursing Home,
Plaintiff-Appellant,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Defendant-Appellee.

ON APPEAL from the United States District Court for the Southern District of Ohio

Decided and Filed November 5, 1991

Before: MARTIN and JONES, Circuit Judges; and BROWN, Senior Circuit Judge.

BROWN, Senior Circuit Judge, delivered the opinion of the court, in which MARTIN, Circuit Judge, joined. JONES, Circuit Judge, concurred in the result.

BAILEY BROWN, Senior Circuit Judge. Westchester Management Corporation d.b.a Salem Park Nursing Home ("Westchester Management") appeals the district court's dismissal of its action against the United States Department of Health and Human Services. The district court determined

that it lacked subject-matter jurisdiction of this action seeking judicial review of a denial of reimbursement for certain facility rental expenses claimed under the Medicare Act. Because we conclude that the district court lacked subject-matter jurisdiction, we affirm.

I.

This appeal from the district court's dismissal of Westchester Management's complaint for lack of subject-matter jurisdiction requires that we "assume all material facts alleged in [Westchester Management's] complaint are true and construe the complaint liberally, giving [Westchester Management] the benefit of any doubt." *Livingston Care Ctr., Inc.* v. *United States*, 934 F.2d 719, 720 (6th Cir. 1991) (citation omitted), *petition for cert. filed*, (Aug. 27, 1991).

Subruban Nursing and Mobile Homes, Inc. ("Suburban") leased the facility known as Salem Park Nursing Home ("Salem Park") to Westchester Management for ten years, beginning on January 1, 1977. When the parties executed the lease, Suburban and Westchester Management were related by common ownership or control. Under regulations controlling Medicare reimbursement, costs of facilities supplied to a health care provider by an entity related to the provider by common ownership or control were reimbursable only to the extent of the cost to the related entity of the facility supplied to the provider. *See* 42 C.F.R. § 405.427 (1984).[1] Prior to December, 1982, Parke Care Centers, Inc. ("Parke"), which is not related to Suburban by common ownership or control, purchased all of the outstanding shares of Westchester Management, acquiring all of its assets, including its rights under the lease. This transaction occurred prior to the controversy that resulted in this litigation.

Westchester Management receives reimbursement pay-

[1] The current version of this regulation is codified at 42 C.F.R. § 413.17 (1990).

ments, under Part A of the Medicare Act,[2] for health care services provided at Salem Park. During 1986, Community Mutual Insurance Company ("CMI"), the "fiscal intermediary" charged by the government with reviewing Westchester Management's reimbursement claims,[3] notified Westchester Management that it intended to disallow part of Westchester Management's claim for 1984. CMI applied the related-entity regulation to the amounts Westchester Management claimed as rental expense for the Salem Park facility and, for this reason, reduced its reimbursement. The amount CMI disallowed was greater than $1,000 but less than $10,000.

If a health care provider disputes a fiscal intermediary's disallowance of a claim for reimbursement, and the amount in controversy exceeds $10,000 (or $50,000 for the aggregated claims of several providers that alone could not satisfy the $10,000 requirement), then the provider is entitled to appeal the disallowance to the Provider Reimbursement Review Board (the "Board"). *See* 42 U.S.C. § 1395oo(a) and (b). The Medicare Act contains a grant of subject-matter jurisdiction for judicial review of the Board's final decision. *See* 42 U.S.C. § 1395oo(f). When, however, the total amount in controversy is between $1,000 and $10,000, as it is in this dispute, review by the Board is unavailable. Instead, the provider is entitled to a hearing before a fiscal intermediary. *See* 42 C.F.R.

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[2] "Part A of the Medicare Act provides insurance for hospitalization and post-hospitalization costs. Part B provides supplemental insurance that covers other medical and health services." *Bodimetric Health Servs. v. Aetna Life & Cas.*, 903 F.2d 480, 482 n.2 (7th Cir.), *cert. denied*, 111 S. Ct. 579 (1990).

[3] Under 42 U.S.C. § 1395h, the Secretary of Health and Human Services is empowered to contract with "fiscal intermediaries," such as insurance companies, which then review the cost reports submitted annually by the health care providers. The fiscal intermediaries review the reports for compliance with the Medicare Act, the regulations promulgated thereunder, and the directives of the Secretary compiled in the Medicare Provider Reimbursement Manual.

§§ 405.1809, 405.1811, and 405.1817 (1984). Westchester Management obtained such a hearing, and the hearing officer determined that CMI properly disallowed the claim. The hearing officer first noted that, although Westchester Management was not related to Suburban during 1984, the year the expenses that are at issue here were incurred, it *was* related to Suburban when the lease was executed. The hearing officer next looked to the Medicare Provider Reimbursement Manual (the "Provider Manual"), which provides as follows:

> If a provider and a supplier are related by common ownership or control at the time of executing a supply contract, the provider's allowable cost will be governed by the related organization principle throughout the full term of the supply contract, even if the common ownership or control terminates before the end of the contract.

Medicare Provider Reimbursement Manual, HCFA Pub. 15-1, § 1011.2 (12/83). The hearing officer concluded that, because Westchester Managment was related to the owner of Salem Park at the time of the execution of the lease, this instruction of the Secretary contained in the Provider Manual mandated the disallowance. Finally, the hearing officer noted that he lacked the authority to disobey an instruction of the Secretary.

The decision of a hearing officer is final, except that, upon motion of the provider or at its own discretion, the Health Care Financing Administration ("HCFA") may conduct a review of the decision. *See* 42 C.F.R. § 405.1833 (1984). Westchester Management sought and obtained such review by an HCFA review officer, who affirmed the decision. No appeal from the decision of the HCFA officer is available, and the Medicare Act's statutory grant of subject-matter jurisdiction for judicial review extends only to disputes that are finally decided by the Board. Board review, as stated, is available only when the amount in controversy exceeds

$10,000 for one provider or $50,000 for a group of similarly aggrieved providers.

After the final decision of the HCFA review officer, Westchester Management filed this suit.[4] It alleged that the application of the related-entity regulation violated the Administrative Procedure Act, the Medicare Act, and the Due Process Clause. The district court dismissed the complaint for lack of subject-matter jurisdiction.

II.

The Medicare Act contains its own statutory grant of subject-matter jurisdiction. *See* 42 U.S.C. § 1395oo(f)(1). This avenue of judicial review is, as stated, open only when there is a final decision by the Board. *See id.* As also noted above, review by the Board is available only when the amount in controversy exceeds $10,000 for one provider or $50,000 for a group of providers. *See* 42 U.S.C. § 1395oo(a)(2) and (b). Because the amount in controversy in this dispute is less than $10,000, the district court could not assert subject-matter jurisdiction under 42 U.S.C. § 1395oo(f)(1).

Westchester Management does not here, as stated, rely upon 42 U.S.C. § 1395oo(f)(1). Instead, it relies only upon 28 U.S.C. §§ 1331 and 1346. The district court determined that the Medicare Act foreclosed the exercise of subject-matter jurisdiction under 28 U.S.C. §§ 1331 and 1346. In reaching this conclusion, it first noted that 42 U.S.C. § 1395ii incorporates into the Medicare Act 42 U.S.C. § 405(h), a provision of the Social Security Act. 42 U.S.C. § 405(h) provides as follows:

> The findings and decision of the Secretary after a hearing shall be binding upon all individuals who

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[4] Initially, Westchester Management relied on 42 U.S.C. § 1395oo(f)(1) for jurisdiction. Later, however, it abandoned that statute as a basis for jurisdiction and asserted 28 U.S.C. §§ 1331 and 1346.

> were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. *No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.*

42 U.S.C. § 405(h) (emphasis added). The district court determined that, because Westchester Management's claims arise under the Medicare Act, 42 U.S.C. § 405(h) precluded it from exercising subject-matter jurisdiction under 28 U.S.C. §§ 1331 and 1346.

This simple and straightforward analysis by the district court forms the background of the parties' dispute. Westchester Management asserts on appeal that its claims arise not under the Medicare Act, but under the Due Process Clause and the Administrative Procedure Act. It contends, therefore, that subject-matter jurisdiction exists under 28 U.S.C. §§ 1331 and 1346. It finds support for its position in *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986).

Westchester management contends that *Michigan Academy* requires that 42 U.S.C. § 405(h) be construed to preclude only challenges to amount determinations, not challenges to the validity of the Secretary's regulations and instructions. It further asserts that it challenges an instruction of the Secretary contained in the Provider Manual, not an amount determination. Relying on *Michigan Academy*, it claims that subject-matter jurisdiction for this challenge exists under 28 U.S.C. §§ 1331 and 1346.

In response, the government contends that all of Westchester Management's claims arise under the Medicare Act and that the district court could not, under these circumstances, exercise subject-matter jurisdiction over them. The government first notes that the Supreme Court has indicated that the "arising under" language of 42 U.S.C. § 405(h) should be construed broadly. *See Weinberger* v.

Salfi, 422 U.S. 749, 760-62 (1975). Accordingly, the government points out, the Supreme Court previously has found that constitutional and statutory challenges to an instruction of the Secretary, such as Westchester Management's challenge here, arise under the Medicare Act. *See Heckler* v. *Ringer*, 466 U.S. 602, 615 (1984); *cf. Salfi*, 422 U.S. at 761. Finally, the government asserts that when Congress expressly creates a forum for judicial review of agency action, as it has here in 42 U.S.C. § 1395oo(f)(1), claimants must meet all of the requirements that Congress imposes for access to that forum. *See Ringer*, 466 U.S. 614-18. These assertions lead to the government's conclusion that Westchester Management's claims must be deemed to arise under the Medicare Act and that a provider like Westchester Management may obtain judicial review of its claims only under 42 U.S.C. § 1395oo (f)(1); 42 U.S.C. § 405(h) precludes subject-matter jurisdiction under 28 U.S.C. §§ 1331 and 1346.

The government's argument is correct. Although Westchester Management correctly points out that *Michigan Academy* creates an exception to 42 U.S.C. § 405(h) that allows courts to exercise subject-matter jurisdiction of certain Medicare claims under 28 U.S.C. §§ 1331 and 1346, that exception is inapplicable in this case. As we have previously indicated, the *Michigan Academy* exception applies only when there is no other avenue of judicial review. *See Good Samaritan Medical Center* v. *Sec. of Health*, 776 F.2d 594, 597-98 (6th Cir. 1985). In *Good Samaritan*, we concluded that the *Michigan Academy* exception was inapplicable because 42 U.S.C. § 1395oo(f)(1) provided an avenue of judicial review for the type of claim that the claimants made in that case. *See id.* The same statute, 42 U.S.C. § 1395oo (f)(1), provides an avenue of judicial review fo the type of challenge that Westchester Management asserts.

We are well aware that we decided *Good Samaritan* prior to the Supreme Court's decision in *Michigan Academy*. In *Good Samaritan*, we relied on our own decision in the *Michigan Academy* case, which was affirmed by the Supreme

Court's decision in *Michigan Academy*. *Good Samaritan* remains good law.

Congress has expressly provided for judicial review of the type of claim that Westchester Management asserts, when the claim exceeds the $10,000 amount-in-controversy requirement. Congress created a special procedure by which a provider that, unlike Westchester Management, is entitled to a Board hearing may demand that the Board determine whether it has authority to pass on a relevant legal question, such as the validity of an instruction of the Secretary. If it determines that it lacks authority, the provider may proceed directly to court for judicial review of its legal challenge. *See* 42 U.S.C. § 1305oo(f)(1). If we were to accept Westchester Management's construction of *Michigan Academy* — that there is always jurisdiction under 28 U.S.C. §§ 1331 and 1346 for challenges to instructions, rules, and regulations, but not for amount determinations — this special procedure, created by 42 U.S.C. § 1395oo(f)(1), would become superfluous.

The better construction requires that Westchester Management pursue the exclusive jurisdictional grant within the Medicare Act. Its claim that it has no avenue of judicial review is meritless; 42 U.S.C. § 1395oo(f)(1) provides an avenue of judicial review for the sort of challenge to the validity of the Secretary's instructions that it raises. Westchester Management is, however, denied access to that avenue because it is unable to meet the amount-in-controversy requirement. There is no contention that Congress lacks the power to limit jurisdiction by prescribing minimum amount-in-controversy requirements.

We determine that subject-matter jurisdiction may not be based on 28 U.S.C. §§ 1331 and 1346. For the foregoing reasons, the district court's dismissal of Westchester Management's complaint is **AFFIRMED**.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

No. C-1-90-0559

WESTCHESTER MANAGEMENT CORP.,
d/b/a Salem Park Nursing Home,
Plaintiff,

vs.

THE UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES,
Defendant.

ORDER GRANTING DEFENDANT'S MOTION TO DISMISS
(Filed January 28, 1991)

This matter is before the Court on defendant's motion to dismiss for lack of subject matter jurisdiction (doc. 3). The plaintiff responded (doc. 4), and the defendant replied (doc. 6). The plaintiff, Westchester Management Corporation (d/b/a Salem Park Nursing Home), is a skilled nursing facility operating under the Medicare program, 42 U.S.C. § 1395 *et seq*. Community Mutual Insurance Company (acting as Medicare's fiscal intermediary) disallowed certain costs claimed by plaintiff on its 1984 Medicare cost report. The plaintiff then sought a hearing before a hearing officer for the Blue Cross and Blue Shield Association. The hearing officer affirmed Community Mutual's decision. Plaintiff now seeks a review of that decision by this Court.

The defendant in this action has filed a motion to dismiss on the grounds that this Court lacks jurisdiction to proceed with this matter. The plaintiff asserts that this Court has jurisdiction pursuant to 28 U.S.C. § 1331, 28 U.S.C. § 1346

and 42 U.S.C. § 1395oo(f)(1). For the reasons set forth below, defendant's motion to dismiss must be granted.

The Medicare program was created as an amendment to the Social Security Act in 1965. Under Part A of the program, eligible beneficiaries obtain health care services from "providers of services" such as the plaintiff. The providers are reimbursed by the government, usually through fiscal intermediaries under contract with the Secretary such as Community Mutual Insurance.

The determination of the amount of reimbursement due a provider is made by the fiscal intermediary in accordance with the statute, regulations and agency manuals. If the amount in controversy is $10,000 or more, a provider may request a hearing to review the intermediary's decision before the Provider Reimbursement Review Baord (PRRB). 42 U.S.C. § 1395oo(f)(1). If the amount in controversy is less than $10,000 but equal to or greater than $1,000, the provider is entitled to an administrative hearing before the intermediary pursuant to 42 C.F.R. § 405.1809(b)(2). A Health Care Financing Administration (HCFA) review officer may review the intermediary hearing officer's decision at the request of the provider or at the discretion of the HCFA pursuant to HCFA Pub. 15-1, § 2917 (2/85).

It is well settled that the United States District Courts only possess the jurisdiction that Congress has conferred on them. *South Carolina* v. *Katzenbach*, 383 U.S. 301 (1966). The plaintiff in this action alleges jurisdiction pursuant to 28 U.S.C. § 1331, 28 U.S.C. § 1346 and 42 U.S.C. § 1395oo (f)(1). 28 U.S.C. § 1331 entitles the district courts to "original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States." 28 U.S.C. § 1346(a)(2) entitles district courts to original jurisdiction over claims against the United States "founded upon the Constitution, or any Act of Congress, or any regulation of an executive department . . . ." However, 42 U.S.C. § 405(h) states that the Secretary's decisions made after a hearing shall be binding on all parties to that hearing. Section 405(h) further specifies,

"No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter." 42 U.S.C. § 405 is part of the Social Security Act, but 42 U.S.C. § 1395ii incorporates § 405(h) into the Medicare Act. 42 U.S.C. § 1395ii states:

> The provisions of sections 406 and 416(j) of this title, and of subsections (a), (d), (e), (h), (i), (j), (k), and (l) of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter.

Therefore, 42 U.S.C. § 405(h) via 42 U.S.C. § 1395ii specifically denies federal jurisdiction under 28 U.S.C. § 1331 or 28 U.S.C. § 1346 for claims arising under the Medicare Act.

The plaintiff next asserts that 42 U.S.C. § 1395oo(f)(1) empowers this Court to review the intermediary's decision in this case. However, § 1395oo(f)(1) grants district court review only of Provider Reimbursement Review Board (PRRB) determinations or modifications of those PRRB decisions by the Secretary. A provider is entitled to a PRRB determination pursuant to 42 U.S.C. § 1395oo(a) only if the amount in controversy is $10,000 or more. 42 U.S.C. § 1395oo(a)(2). The plaintiff in this case has specifically alleged in his complaint that the amount in controversy is between $1,000 and $9,999. Therefore, this Court does not possess jurisdiction over this matter.

Where the amount in controversy is at least $1,000 but less than $10,000, 42 C.F.R. § 405.1809(b)(2) entitles the provider to an intermediary review. The plaintiff in this action was entitled to an administrative review by the Blue Cross Blue Shield Association as Medicare's intermediary. The plaintiff received a hearing before a hearing officer for the Blue Cross Blue Shield Association which issued a written decision affirming Community Mutual's adjustments. The plaintiff was further entitled to an appeal of the in-

termediary's decision to the Director of the Hearings Staff for HCFA. On June 5, 1990, a hearing officer of HCFA affirmed the intermediary's decision. As set forth above, this Court has not been granted jurisdiction to review the HCFA's decision. In fact, the Provider Reimbursement Manual specifically states that "[t]here is no appeal from the decision of an HCFA review officer." HCFA Pub. 15-1, § 2917 (2/85).

The plaintiff asserts that the intermediary's reliance on a general instruction of the HCFA that was not enacted as a law is an unconstitutional use of an unpromulgated rule. Plaintiff further asserts that after the intermediary's decision was affirmed, the substance of plaintiff's claims rather than the amount of reimbursement in dispute determines its right to judicial review. However, the United States Supreme Court stated, "[T]o be true to the language of the statute, the inquiry in determining whether § 405(h) bars federal-question jurisdiction must be whether the claim 'arises under' the Act, not whether it lends itself to a 'substantive' rather than a 'procedural' label." *Heckler* v. *Ringer*, 466 U.S. 602, 615 (1984). That Court has further stated:

> [§ 405(h)'s] reach is not limited to decisions of the Secretary on issues of law or fact. Rather, it extends to any 'action' seeking 'to recover on any [Social Security] claim' — irrespective of whether resort to judicial processes is necessitated by discretionary decisions of the Secretary or by his nondiscretionary application of allegedly unconstitutional statutory restrictions.

Weinberger v. *Salfi*, 422 U.S. 749, 762 (1975).

The plaintiff in this case has failed to meet the jurisdictional requirements set forth by Congress for challenging an adverse determination by the Secretary. Plaintiff's argument that it has stated a constitutional issue does not empower this Court to exercise jurisdiction. Congress, as stated above, clearly limited judicial review to cases involving at least $10,000. Congress included, in 42 U.S.C. § 1395oo(b), a provision whereby groups of providers could aggregate claims in-

volving common questions of fact or law that total at least $50,000 to entitle them to review before the Board (and thus judicial review) without regard to the $10,000 jurisdictional limitation. Congress modified this legislation prior to enactment to provide for such groups, but did not amend the $10,000 requirement for individual providers. *See* S.Rep. No. 92-1230, 92d Congress, 2d Session 248-49 (1972) and H.Rep. No. 92-1605, 92d Congress 2d Session 54-55 (1972). Thus, it appears from the legislative history that Congress was aware that in limiting Board review to cases in which at least $10,000 was in controversy and in providing judicial review only for Board decisions, that it was limiting judicial review to cases involving at least $10,000.

Accordingly, the defendant's motion to dismiss this action for lack of subject matter jurisdiction is hereby granted.

SO ORDERED.

Dated: 1/28/91

/s/ S. ARTHUR SPIEGEL
United States District Judge

HEALTH CARE FINANCING ADMINISTRATION

Review Decision on Behalf of the Secretary of HHS

In the Case of:

Provider No. 35-5480 Salem Park Nursing Home	Claim for: Provider Cost Reimbursement Determination of Reasonable Costs for the Cost Reporting Period Ending December 31, 1984
vs.	Review of:
Community Mutual Blue Cross and Blue Shield	Blue Cross Association Hearing Decision No. 722 Docket No. 90-8

Jurisdiction

The review of this case is undertaken pursuant to procedures adopted by the Health Care Financing Administration in accordance with the decision of the U.S. Court of Appeals in the case of St. Louis University v. Blue Cross Hospital Service, 537 F 2d 283 (8th Cir. 1976). Said decision held that the Secretary must retain sufficient powers of review to assure that fiscal intermediaries comply with the Medicare Act and regulations.

Issue

Whether intermediary hearing officers are bound by general instructions of the Health Care Financing Administration.

Findings

The facts findings and conclusions of the BCA hearing of-

ficer is, hereby, adopted and made part of this decision. This is a dispute involving the question of whether a lease between the provider and its landlord should be treated as a transaction between related parties. A general instruction of the HCFA is right on point and it provides that it should be. See section 1011.2 of the Medicare Long-Term Care Manual (HIM.15)

The provider argues that the BCA hearing officer erred because the aforementioned general instruction is, allegedly, inconsistent with the controlling regulations and is, itself, a "substantive rule" which was not promulgated in accordance with the Administrative Procedures Act. These arguments are appreciated. However, I find that the BCA hearing officer did not err. He had no authority to ignore a general instruction of the Health Care Financing Administration. See 42 CFR 405.1829(a). Both the instruction defining the nature of transaction under consideration and the regulation requiring him to follow the instruction are uncharacteristically clear.

Decision

The determination of the Blue Cross Association hearing officer is affirmed. Intermediary hearing officers are bound by general instructions of the Health Care Financing Administration.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

DATE: 6-5-90

/s/ STANLEY KROSTAR
Hearing Officer
Health Care Financing Administration

Decision No. 772

BLUE CROSS AND BLUE SHIELD ASSOCIATION
MEDICARE PROVIDER APPEAL DECISION
Appeal of
Salem Park Nursing Home
Provider No. 36-5480
From Cost Report Adjustments
Made By
Community Mutual Blue Cross and Blue Shield
For the Cost Reporting Period Ended 12/31/84
BCBSA Case No. 870820

This appeal of a skilled nursing facility (Provider) of cost report adjustments made by a Blue Cross Plan (Plan) was heard on May 19, 1989 by Fred V. Amundsen, Chief Hearing Officer, Blue Cross and Blue Shield Association. The decision of the Hearing Officer is based on the record of the appeal which includes the transcript of the hearing, exhibits presented at the hearing, material submitted by the Provider and Plan, and regulations, instructions, and other references listed on the exhibit to this decision.

The Provider is one of five certified skilled nursing facilities that comprise Park Care Centers, Inc. The other chain providers are party to this appeal under the provisions of HCFA Pub. 15-1, Section 2914.9.

The reimbursement in dispute for this Provider is between $1,000 and $9,999, and the reimbursement in controversy for all the chain providers is less than $50,000. Therefore, the Intermediary Hearing Officer has jurisdiction to adjudicate this dispute pursuant to the provisions of 42 CFR 405.1811.

Issues

1) Whether the Plan's disallowance of Home Office costs due to lack of documentation was proper,
2) Whether the Plan properly applied the related organization principal to a) rent paid to SNMH, b) accounting fees paid to NHC.

One issue, application of the related organization principle to HOPS, was resolved during the hearing.

Issue 1 — Home Office Cost — Facts and Background

The Provider claimed $23,329, 11.19% of total home office cost ($199,574). Adjustment number 1 eliminated all claimed home office (Park Care Centers, Inc.) cost from the Provider's allowable cost.

> The Provider did not file a home office cost report for 1984, the year under appeal. However, it did begin filing home office cost reports for the 1985 period and thereafter. The Plan audited the 1985 cost report and allowed an 11.49% allocation of pooled home office cost ($19,889) plus $2,988 direct home office cost for this Provider for a total of $22,877 out of $185,114 total 1985 home office cost.

Issue 1 — Provider Position

> The Provider maintains that it was not aware that the Plan needed home office records until after the home office had terminated its contract with its accounting service, which also provided central location for storage of all its records. After termination of the contract, it has been difficult to get records from them.

Issue 1 — Plan Position

> The Plan explains that it disallowed all home office costs claimed because the Provider did not submit a home office cost report, and the Plan has not been able to examine the records of Park Care Centers, Inc. Although Medicaid did audit the 1984 home office cost, the Plan is not willing to accept the audit results of that agency. It is willing to review home office financial statements or tax returns to determine allowable home office cost.

Findings and Conclusions of the Hearing Officer — Issue 1

At the hearing, the Plan agreed to use alternative documents such as financial statements or tax returns to arrive at a conclusion as to the reasonableness of the claimed home office costs. The Provider offered to make such documents available to the Plan.

The Provider's submission of December 11, 1989 did include work schedules for the home office costs for the period ending December 31, 1986 which is not the year under appeal. The Hearing Officer has not received any additional documents relating the 1984 home office costs.

Hearing Officer's Decision — Issue 1

The Plan is authorized to modify its adjustment if the Provider submits satisfactory documentation of the 1984 home office costs.

Issue 2a — Related Organization Principle Applied to Rent — Facts and Background

Park Care Centers, Inc. rents buildings under a 10 year lease from SNMH. The Plan eliminated all rental payments due to a determination that the Provider and SNMH were related by common ownership at the time the lease was signed, January 1, 1977. Costs of ownership were not substituted for the disallowed rent payments due to lack of documentation.

At the time the lease was signed, Park Care Centers was entirely owned by Gerald Keller. His nephew, James Thornton, subsequently purchased the Chain. Gerald Keller and his family held 100% of the stock of SNMH, and G. Keller and James and Dora Thornton were Director/Officers at this time. After G. Keller's death in 1982, his stock was in trust and the Director/Officers were his wife and children.

Issue 2a — Provider's Position

The Provider agrees that the rental contract executed in 1977 was between related parties but maintains that the par-

ties were not related during the fiscal year under appeal. At the time Park Care was organized and when Park Care negotiated the purchase of the stock with SNMH, there was not common ownership or control. Park Care was its own independent, free-standing company with no control or common ownership in SNMH or SNMH into it. The ownership transferred prior to the issuance of HCFA Pub. 15-1, Section 1011.2, therefore, the Provider argues that Section 1011.1 cannot be relied upon.

The Provider contends that the policy stated in Section 1011.1 was not a continuation of existing policy since there was no similar provision in the Medicare instructions. Section 1011.2 did not exist until December, 1982. Since the adoption of this provision, the leases expired and new leases have been negotiated and executed. The provisions of Section 1011.2 may not be given retroactive effect since that is prohibited by the U.S. Constitution. The Provider argues that it would be contrary to law to rely on Section 1011.1.

The Provider contends that the rental costs at issue are at or below the cost of the ownership ceiling applicable in Ohio. When the ownership changed, the owners elected not to renegotiate the rates because they were at or below what they found to be the normal lease rates in both Hamilton County and in the State of Ohio.

The Provider also argues that the Medicaid auditors found the cost to be reasonable and allowable. The Medicaid auditors and the previous Medicare Intermediary made no related party finding and allowed the rental costs.

Issue 2a — Plan's Position

The Plan argues that common control existed at the inception of the leases and would continue to exist until such time as the leases are modified or replaced. Section 1011.2 states that parties must be governed by the related organization principles even if the common ownership or control terminates before the end of the contract. The Plan also contends that this Section is not new policy but a continuation of existing policy.

Issue 2a — Findings and Conclusions of the Hearing Officer

The Provider has stipulated that leases entered into were between two related parties at the time they were negotiated. The Hearing Officer rejects the Providers' argument that the rental expense should be allowed in full because the lease predated the issuance of HCFA Pub. 15-1 Section 1011.2. Section 1011.2 did not affect any rights of the Provider that existed prior to the publication of Section 1011.2. It did not affect the leases nor impose any new requirements on either party. The leased facilities continued to be furnished to the Providers through an arrangement entered into by related parties. Regulation 405.427 (redesignated 413.17) controls the amount of rent reimbursable under the Medicare program. That regulation was not retroactive in its application.

The Intermediary Hearing Officer is bound by the existing Medicare instructions. Section 1011.2 of HCFA Pub. 15-1 was issued in December, 1982 prior to year under appeal. Transmittal 272, which revised Chapter 10 states that the revision is a clarification of policy. The Hearing Officer finds that the Plan properly applied this instruction.

The Provider should be reimbursed for the costs of ownership of the facility as described in Section 1011.5 of HCFA Pub. 15-1. The Hearing Officer encourages the Provider to give cost data to the Plan so that the Provider may be reimbursed for such costs.

Issue 2a — Decision of the Hearing Officer

The Plan's adjustments are affirmed.

Issue 2b — Related Organization Principle Applied to Fees — Facts and Background

NHC contracted with Park Care Centers to provide accounting, bookkeeping and payroll Services. NHC was owned by Mrs. E. since 1981. The Plan made a determination that Park Center was a related party to NHC. The Provider appealed this determination.

Issue 2b — Provider's Position

The Provider contends that Park Care Centers is not engaged in any way in a related party transaction with NHC. During the year under appeal, NHC is wholly owned by Mrs. E who is not a relative of the stockholder of PCC nor of SNMH. There is no contract nor services rendered by relatives. The contract is between PCC and NHC, is dated June 1, 1981, and is between two separate and distinct corporate entities.

Issue 2B — Plan's Position

The Plan made its related party determination based on longstanding relationships which give the appearance of related organizations. In 1973, Mrs. E. entered into a partnership agreement with the owner of Park Care, and the Plan argues that no evidence was provided which shows that this partnership has terminated. The Plan also notes that Mrs. E is an officer at SNH which the Plan considers to be a related organization.

Issue 2b — Findings and Conclusions of the Hearing Officer

The Hearing Officer finds that the Plan has not presented any evidence that establishes that PCC is related to NHC. The partnership agreement cited by the Plan would not create a related organization, and that partnerhsip was terminated prior to the year under appeal. The Hearing Officer finds that the Officership position held by Mrs. E. in SNH would not create a related organization between PCC and NHC.

Issue 2b — Hearing Officer's Decision

The Plan's adjustment is reversed.

medicare
Provider Reimbursement Manual
Part 1

Department of Health and Human Services
Health Care Financing Administration

Transmittal No. 272
Date December 1982

NEW MATERIAL	PAGE NO.	REPLACED PAGES
Table of Contents		
Chapter 10	10-1 (1 p.)	10-1 (1 p.)
Sec. 1000-1011.7	10-3-10-11 (9 pp.)	10-3-3-7 (5 pp.)

Chapter 10, Cost to Related Organizations, has been revised to clarify the principle by adding new examples and revising the explanatory language. Some of the material in the chapter has been reorganized as indicated below.

CLARIFICATION—EFFECTIVE DATE: Not Applicable

Section 1000, Principle, has been revised to clearly state the purpose of the principle.

Section 1004, Determination of Common Ownership or Control in the Provider Organization and Supplying Organization, has been revised to specifically provide for determining common ownership or control through certain family relationships.

Section 1004.1, Common Ownership Rule, has been revised to emphasize that the examples are for illustrative purposes only, to title the examples, and to provide a new example showing the effect of attribution of ownership on the determination of common ownership.

Section 1004.4, Examples of Control, has been revised to title the examples and to provide a new example showing how control may be established through contracts.

Section 1005, Determination of a Related Organization's Costs, has been added to clarify that the principles of reimbursement for providers must be followed in determining the related organization's costs. Certain specific exceptions to this general principle are specified in this section. Provision has also been made for documenting the related organization's costs.

Section 1006, Rental Expense Paid to a Related Organization, and **Section 1008, Purchase of Facilities from Related Organizations**, have been moved to new subsections 1011.5 and 1011.4 respectively. These new subsections are under new section 1011, Special Applications.

Section 1010, Exception to the Related Organization Principle, has been revised to add substantial clarifying language.

Section 1010.1, Examples of Applying the Exception, has been revised to clarify the opening paragraph and to add an example clarifying that the exception may not be applied to supply contracts in situations where the supply contract itself creates the relationship through control.

Section 1011, Special Applications, has been added to clarify the application of the related organization principle in certain special situations.

Section 1011.1, Contracts Creating Relationships, has been added to clarify that the related organization principle applies in determining a provider's allowable costs for a supply contract in situations where the relationship is created concurrently with the execution of the contract, even though the provider and the supplier were not related prior to execution of the contract.

Section 1011.2, Termination of Relationship, has been added to clarify that a contract entered into between related

organizations will continue to be treated as between related organizations in situations where the relationship terminates before the end of the contract.

Section 1011.3, Disposal of Assets, has been moved from former section 1014.

Section 1011.4, Purchase of Facilities from Related Organizations, has been moved from former section 1008 and has been modified to delete the language that formerly excluded such transactions from consideration under the exception provisions of section 1010.

Section 1011.5, Rental Expense Paid to a Related Organization, has been moved from former section 1006.

Section 1011.6, Shared-Services Organizations, has been added to clarify that the related organization principle applies to shared-services organizations in the same manner as it would to any other supplier.

Section 1011.7, Special Purpose Organizations, has been added to clarify how the related organization principle applies to special purpose organizations that are created from provider reorganizations.

( ) = New Material

NOTE TO FISCAL INTERMEDIARIES: We wish to emphasize that the percentages used in the examples in this transmittal are for illustrative purposes only, and are no way intended to prescribe objective rules for applying the principles illustrated.

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO, WESTERN DIVISION

Case No. C-1-90-55
Judge _____

Westchester Management Corp.
dba Salem Park Nursing Home
c/o Park Care Center, Inc.
11223 Cornell Park Drive
Cincinnati, OH 45242,

Plaintiff,

v.

The United States Department
of Health and Human Services
200 Independence Avenue
Washington, D.C. 20201,

Defendant.

COMPLAINT
(Filed August 2, 1990)

Parties

1. Plaintiff owns and operates a skilled nursing home facility in Cincinnati, Ohio. Plaintiff is certified to operate one hundred seven (107) intermediate care and skilled care nursing home beds at Salem Park Nursing Home, and for all times pertinent to this action has participated in the Medicare Program, pursuant to contract, as a provider of services.

2. Defendant is The United States Department of Health and Human Services, the federal agency responsible for administering the Medicare Program (ref. 42 U.S.C. § 1395, *et seq.*).

Jurisdiction

3. Pursuant to 28 U.S.C. §§ 1331, 1346 and 42 U.S.C § 1395oo(f)(1) Plaintiff timely seeks judicial review of the June, 1990, final administrative decision of the Secretary of the United States Department of Health and Human Services by the United States District Court, Southern District, Western Division, which is located within the judicial district in which Plaintiff is located. By virtue of this specific statutory authority, the United States District Court, Southern District, Western Division, has subject matter jurisdiction to hear Plaintiff's complaint on the merits.

Statement of Facts

4. During the period at issue Plaintiff leased the facility known as Salem Park Nursing Home from Suburban Nursing and Mobile Homes, Inc., the owner of the land, buildings and equipment comprising this nursing home business pursuant to a ten year rental contract. This rental contract was executed by Suburban Nursing and Mobile Homes, Inc. and Plaintiff on January 1, 1977. Prior to December, 1982, Parke Care Centers, Inc. purchased all issued and outstanding shares of Plaintiff and the assets of Plaintiff. The lease agreement for this nursing home was not renegotiated by Parke Care Centers, Inc. due to the low rental rate and favorable terms of the lease agreement. Plaintiff and Plaintiff's parent corporation are independent free-standing corporations with no control or common ownership in or emanating from, to, or with Suburban Nursing and Mobile Homes, Inc.

5. At the time of Plaintiff's current stockholders' purchase of Plaintiff's stock there did not exist any regulation or policy of the Health Care Financing Administration (hereinafter "HCFA") which mandated the continuation of related party status for a non-related party purchaser which continued to pay rent under a lease agreement previously entered into by related parties.

6. In December, 1982, HCFA, through the issuance of Pub. 15-1 created Section 1011.2 of the Medicare Manual for

long-term care providers. The language of this manual section provides if a leasing agreement is considered a product of a related party transaction at its inception, it retains this related party status for its entire term, regardless whether the parties to such agreement change.

7. Through the present date the contents of Section 1011.2 of the Medicare Manual for long-term care providers have never been promulgated in rule form pursuant to the Administrative Procedure Act.

8. Pursuant to these facilities' certified skilled care nursing home status Plaintiff receives reimbursement from HCFA for Plaintiff's care of Medicare-covered skilled care nursing home patients residing at these facilities through an intermediary which is retained by HCFA.

9. Pursuant to federal statute and regulation, HCFA, through its retained intermediary, issues audit adjustment reports for skilled care nursing home providers which receive reimbursement from HCFA through an intermediary.

10. HCFA retained Community Mutual Insurance Company (hereinafter "CMI") to act as its intermediary for Medicare Program purposes in the State of Ohio.

11. Although CMI failed to perform an audit for Plaintiff for 1984, CMI nevertheless did issue an audit report for Salem Park Nursing Home for 1984.

12. This audit report of CMI set forth a number of proposed adjustments which were based upon the alleged finding of a related party relationship between Plaintiff and Suburban Nursing and Mobile Homes, Inc. and Plaintiff and Nursing Home Consultants effective for calendar year 1984. This audit adjustment report also proposed the disallowance of certain home office costs for Salem Park Nursing Home due to an alleged lack of adequate documentation.

13. On February 28, 1986, CMI issued a notice of amount of Medicare Program reimbursement to Salem Park Nursing Home. Within this notice was set forth not only a schedule of amounts disallowed by CMI, but also Salem Park Nursing Home's right to request a hearing in writing. Per this notice, Salem Park Nursing Home had the right to seek a

hearing before the Provider Reimbursement Board or the Appeals Coordinator of Blue Cross and Blue Shield Association. The actual amounts of adjustments to be disputed by Salem Park Nursing Home determined where this provider was to file its appeal from these adjustments.

14. Because the amount of adjustments in dispute affected reimbursement for Salem Park Nursing Home in a total amount between one thousand dollars and nine thousand nine hundred ninety-nine dollars, Salem Park Nursing Home filed its appeal with Blue Cross and Blue Shield Association of Chicago, Illinois. Accordingly, Blue Cross and Blue Shield Association had jurisdiction to adjudicate Salem Park Nursing Home's appeal pursuant to 42 C.F.R. 405.1811.

15. Through the filing of a position paper and supplemental position paper and the presentation of evidence at hearing Salem Park Nursing Home disputed CMI's disallowance of home office costs and implementation of related party findings to rent paid by Salem Park Nursing Home to Suburban Nursing and Mobile Homes, Inc. and accounting fees paid by Salem Park Nursing Home to Nursing Home Consultants.

16. After a hearing was completed a hearing officer for the Blue Cross and Blue Shield Association issued a written decision regarding Salem Park Nursing Home's appeal.

17. This hearing officer ruled CMI could modify its adjustments to Salem Park Nursing Home's home office costs "if the provider submits satisfactory documentation on the 1984 home office costs."

18. The hearing officer went on to affirm CMI's adjustments against all rental payments made by Salem Park Nursing Home to Suburban Nursing and Mobile Homes, Inc. for calendar year 1984. The hearing officer found this provider's stipulation as to the related party status of the leasing parties at the date of the execution of the rental contract (1977) to be determinative. Although the hearing officer did *not* find a related party relationship to exist between Salem Park Nursing Home and Suburban Nursing and Mobile Homes, Inc. in 1984, he ruled HCFA's issuance of Pub. 15-1

Section 1011.2 of the Medicare Manual for long-term care providers dictated a related party finding between these entities for 1984.

19. This hearing officer ruled he is bound by all Medicare instructions in existence for calendar year 1984. He concluded Section 1011.2 by being issued prior to the year under appeal by Plaintiff "did not affect any rights of the provider that existed prior to the publication of Section 1011.2." Within his decision, the hearing officer failed to address the effect of the contents of Section 1011.2 of HCFA Pub. 15-1 never being promulgated as a rule.

20. The hearing officer overruled CMI's finding of a related party relationship between Salem Park Nursing Home and Nursing Home Consultants. He found CMI had failed to present any evidence Plaintiff was engaged in any way in a related party transaction with Nursing Home Consultants, an entity which provided accounting services to Plaintiff for Salem Park Nursing Home's operations in 1984.

21. Plaintiff timely requested the Director of the Hearings Staff for HCFA to review this Hearing Officer's findings and conclusions which declared a related party transaction to exist between Plaintiff and Suburban Nursing and Mobile Homes, Inc.

22. Plaintiff, within this request for review, sought a reversal of the hearing officer's affirmation of CMI's related party adjustments. Plaintiff based this request upon HCFA's failure to promulgate the contents of Section 1011.2 of HCFA Pub. 15-1 as a substantive rule.

23. On June 5, 1990, a hearing officer of HCFA affirmed this disputed determination of the Blue Cross and Blue Shield Association's hearing officer within a Final Administrative Decision of the Secretary of the United States Department of Health and Human Services.

24. This decision of the Secretary found "Intermediary hearing officers are bound by general instructions of the Health Care Financing Administration." Although this hearing officer of HCFA "appreciated" Plaintiff's arguments regarding HCFA's failure to promulgate Section 1011.2 he

concluded CMI's hearing officer "had *no authority* to ignore a general instruction of the Health Care Financing Administration" (emphasis added).

Statement of Jurisdiction

25. Pursuant to 42 U.S.C. § 1395oo(f)(1) Plaintiff timely seeks judicial review of the June 5, 1990, final administrative decision of the Secretary of the United States Department of Health and Human Services by the United States District Court, Southern District, Western Division, which is located within the judicial district in which Plaintiff is located. By virtue of this specific statutory authority, the United States District Court, Southern District, Western Division, has subject matter jurisdiction to hear Plaintiff's complaint on the merits.

First Claim

26. Paragraphs 1 through 25 of Plaintiff's complaint is incorporated by reference as if fully rewritten herein.

27. The Secretary of the United States Department of Health Human Services committed reversible material error through its affirmation of CMI's Hearing Officer's Decision.

28. The Secretary's decision is arbitrary, capricious, an abuse of discretion, and contrary to law.

29. The "related party" adjustments made by CMI which causes all of Plaintiff's rental payments to Suburban Nursing and Mobile Homes, Inc. to be disallowed for 1984 are arbitrary, capricious and grounded upon no substantive basis.

30. Pursuant to 5 U.S.C. § 706(2)(A) and (C) the June 5, 1990, final decision of the Secretary should be reversed.

Second Claim

31. Paragraphs 1 through 25 of Plaintiff's complaint is incorporated by reference as if fully rewritten herein.

32. The Secretary of the United States Department of Health and Human Services' application of Section 1011.2 of

HCFA Pub. 15-1 to Salem Park Nursing Home's calendar year 1984 audit period constitutes an improper use of an unpromulgated rule, an unconstitutional retroactive implementation and/or change of law, and a denial of Due Process.

33. Plaintiff states HCFA's use of Section 1011.2 of HCFA Pub. 15-1 in affirming CMI's related party adjustments against Salem Park Nursing Home violates the Due Process Clause of the Fourteenth Amendment to the Constitution of the United States and 42 U.S.C. § 1395, *et seq.*, including, without limitation, 42 U.S.C. 1395x(v)(1)(A) and 5 U.S.C. § 553(b), et seq., including, without limitation.

WHEREFORE, Plaintiff prays for the following relief:

A. This United States District Court reverse the Secretary of the United States Department of Health and Human Services decision of June 5, 1990;

B. This United States District Court order this matter remanded to Secretary and command the "related party" adjustments of Community Mutual Blue Cross and Blue Shield Association which were directed at Salem Park Nursing Home and affirmed by the Secretary be removed;

C. This United States District Court declare HCFA's application of Section 1011.2 of HCFA Pub. 15-1 to Salem Park Nursing Home's calendar year 1984 audit period to be an improper use of an unpromulgated rule, an unconstitutional retroactive implementation and/or change of law, and a denial of due process in violation of the Due Process Clause of the Fourteenth Amendment to the Constitution of the United States and 42 U.S.C. § 1395 and 5 U.S.C. § 553;

D. This United States District Court order the finding made by Community Mutual Blue Cross and Blue Shield Association of a related party relationship existing between Plaintiff and Suburban Nursing and Mobile Homes, Inc. for calendar year 1984 not be applied to Salem Park Nursing Home; and

E. This United States District Court grant Plaintiff's costs and attorney fees in this action.

Respectfully submitted,

/s/ GEOFFREY E. WEBSTER

/s/ RICHARD GOLDBERG

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Supreme Court, U.S.
FILED
APR 10 1992
OFFICE OF THE CLERK

(2)

No. 91-1197

In the Supreme Court of the United States

OCTOBER TERM, 1991

WESTCHESTER MANAGEMENT CORP.
dba SALEM PARK NURSING HOME, PETITIONER

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Whether the district court lacked jurisdiction over petitioner's claim for reimbursement of rental expenses under the Medicare Act because the claim did not meet the $10,000 amount-in-controversy requirement of 42 U.S.C. 1395*oo*.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statement	2
Argument	7
Conclusion	14

TABLE OF AUTHORITIES

Cases:

Bartlett v. *Bowen*:	
816 F.2d 695 (D.C. Cir. 1987)	12, 13
824 F.2d 1240 (D.C. Cir. 1987)	12, 13
Beverly Hospital v. *Bowen*, 872 F.2d 483 (D.C. Cir. 1989)	12
Block v. *Community Nutrition Institiute*, 467 U.S. 340 (1984)	10
Bowen v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986)	7, 9, 10
Christianson v. *Colt Industries Operating Corp.*, 486 U.S. 800 (1988)	7
Heckler v. *Ringer*, 446 U.S. 602 (1984)	9, 10, 11
Sheldon v. *Sill*, 49 U.S. (8 How.) 441 (1850)	7
Weinberger v. *Salfi*, 422 U.S. 749 (1975)	9, 11

Constitution, statutes and regulations:

U.S. Const.:	
Amend. I	12
Amend. V (Due Process Clause)	6
Administrative Procedure Act:	
5 U.S.C. 551-559	6
5 U.S.C. 701-706	6
Health Insurance for the Aged Act (Medicare Act), 42 U.S.C. 1395 *et seq.*	2
42 U.S.C. 1395h(a)	2
42 U.S.C. 1395x(u)	2

Constitution, statutes and regulations—Continued: Page

42 U.S.C. 1395ff(b) 13
42 U.S.C. 1395ff(b)(1)(C) 9
42 U.S.C. 1395ff(b)(2) 9
42 U.S.C. 1395ff(b)(2)(A) 12
42 U.S.C. 1395ii 6, 7, 8, 11
42 U.S.C. 1395*oo* 6, 7, 8, 10, 12, 13
42 U.S.C. 1395*oo*(a) 3
42 U.S.C. 1395*oo*(b) .....
42 U.S.C. 1395*oo*(f) 3
42 U.S.C. 1395*oo*(f)(1) 3, 6, 7
42 U.S.C. 1395*oo*(g) 2
28 U.S.C. 1331 ..... 6, 7, 8, 9, 11
28 U.S.C. 1346 ..... 6, 7, 8, 9
42 U.S.C. 405(h) 6-7, 8, 9, 10, 11
42 C.F.R.:
Section 405.427 (1984) 5, 14
Section 405.1803 2
Section 405.1809 3
Section 405.1817 4
Section 405.1833 4
Section 405.1885 4
Section 413.17 5

Miscellaneous:

Medicare Provider Reimbursement Manual:
HCFA Pub. 15-1 (12/82) 5
HCFA Pub. 15-1 (2/85) 4

In the Supreme Court of the United States

OCTOBER TERM, 1991

No. 91-1197

WESTCHESTER MANAGEMENT CORP.
dba SALEM PARK NURSING HOME, PETITIONER

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 2a-9a) is reported at 948 F.2d 279. The opinion of the district court (Pet. App. 10a-14a) is unreported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 1a) was entered on November 5, 1991. The petition for a writ of certiorari was filed on January 22, 1992. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Under Part A of the Medicare program, 42 U.S.C. 1395 *et seq.*, eligible beneficiaries obtain hospital and post-hospital services from "provider[s] of services," including hospitals, skilled nursing facilities, and home health agencies. See 42 U.S.C. 1395x(u). The government reimburses the providers of services for the services that they provide to beneficiaries.

a. Congress has established a complex system for handling the vast numbers of claims for payment submitted to the Medicare program each year. Congress has authorized the Secretary of Health and Human Services to contract with "fiscal intermediar[ies]," primarily insurance companies, to act as the Secretary's agents in handling claims for payment. 42 U.S.C. 1395h(a). This approach allows the Secretary to draw on the fiscal intermediaries' experience and skill in dealing with claims for payment for medical care.

At the end of each year, a provider of services submits to its fiscal intermediary a cost report for Medicare services rendered during the year. The fiscal intermediary reviews the cost report and applies the Medicare Act, the regulations promulgated under the Act by the Secretary, and other directives of the Secretary contained in the Medicare Provider Reimbursement Manual.[1] After reviewing the cost report, the intermediary issues a Notice of Program Reimbursement to the provider. See 42 C.F.R. 405.1803. This notice specifies the amount of reimbursement to which the intermediary believes the provider is

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[1] In issuing these regulations and directives, the Secretary acts through the Health Care Financing Administration (HCFA).

entitled. The notice also informs the provider of its appeal rights.

If the provider is aggrieved by the notice—and the amount in controversy is $10,000 or more—the provider may appeal to the Provider Reimbursement Review Board (Board). 42 U.S.C. 1395*oo*(a). A group of providers, each of whom would be entitled to appeal to the Board but for the amount-in-controversy requirement, may bring a joint appeal on a common question of fact or law if the aggregate amount in controversy is at least $50,000. 42 U.S.C. 1395*oo*(b). A provider or group of providers that has a right to appeal to the Board may (with exceptions not relevant here) obtain judicial review of the Board's decision by filing a civil action within 60 days after it is rendered. 42 U.S.C. 1395*oo*(f) and (g). The statute also provides for judicial review of an action of a fiscal intermediary, including review of legal issues that the Board may not have authority to decide, by permitting a provider or group of providers that meets the jurisdictional prerequisites for Board review to seek a determination from the Board that a pertinent question of law is beyond its authority to decide. See 42 U.S.C. 1395*oo*(f)(1). When the Board makes such a determination, the provider or group of providers may obtain immediate judicial review of the legal question at issue. *Ibid.*

A single provider aggrieved in an amount between $1,000 and $10,000 is entitled to a hearing before the fiscal intermediary rather than the Board. The hearing is conducted by an officer who is knowledgeable in the field of health care reimbursement and who has had no direct responsibility for the program reimbursement determination with respect to which a request for a hearing was filed. 42 C.F.R. 405.1809,

405.1817. The hearing officer's decision is final and binding unless it is reopened upon motion of the hearing officer or provider, 42 C.F.R. 405.1833, 405.1885, except that upon motion of the provider or at the discretion of HCFA, a HCFA review officer may review the decision. HCFA Pub. 15-1, § 2917 (2/85). There is no appeal from the decision of the HCFA review officer. *Ibid.*

b. The amount of reimbursement to which a provider is entitled is determined in accordance with applicable statutes and regulations issued by the Secretary. This case concerns the Secretary's regulation governing the allowability of costs for services, facilities, and supplies furnished to a provider by an entity related to it by common ownership or control. The regulation applicable to this case provided:

> Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.
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> Where the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, in effect the items are obtained from itself.

42 C.F.R. 405.427 (1984).[2] These provisions prevent corporate Medicare providers from inflating costs by means of intra-corporate transactions that do not add to the actual costs of services.

This case concerns rent paid by a provider under a long-term lease that was signed before a change in the ownership of the provider. The Medicare Provider Reimbursement Manual deals with this situation by providing:

> If a provider and a supplier are related by common ownership or control at the time of executing a supply contract, the provider's allowable costs will be governed by the related organization principle throughout the full term of the supply contract, even if the common ownership or control terminates before the end of the contract.

HCFA Pub. 15-1, § 1011.2 (12/82).

2. Suburban Nursing and Mobile Homes, Inc. (Suburban) owned the facility known as the Salem Park Nursing Home (Salem Park).[3] On January 1, 1977, petitioner leased the facility from Suburban for a ten-year term. At the time of the lease transaction, petitioner and Suburban were related by common ownership or control. Prior to December 1982, Parke Care Centers, Inc., purchased all of petitioner's stock and assets, including its rights under the lease agreement. Parke Care Centers is not related by common ownership or control to Suburban. Pet. App. 3a. On February 28, 1986, the Secretary's fiscal intermediary in Ohio, Community Mutual Insurance

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[2] The regulation is currently located at 42 C.F.R. 413.17.

[3] Because petitioner's complaint was dismissed for lack of jurisdiction, the facts alleged in the complaint are assumed to be true. See Pet. App. 3a.

Company (CMI), issued a Notice of Program Reimbursement to Salem Park based on its cost report for 1984. Applying the related-entity regulation set out above, CMI found that petitioner and Suburban were related parties in 1984, and that a portion of the rental payments made under the lease contract therefore must be disallowed. The total amount of the adjustments was greater than $1,000 but less than $10,000. Pet. App. 4a.

Petitioner exercised its right to request a hearing before CMI. The hearing officer did not find that petitioner and Suburban were related parties in 1984. But the hearing officer, applying Section 1011.2 of the Provider Reimbursement Manual quoted above, determined that rental payments made under the lease agreement were subject to the related-party principle because of the relationship between the parties to the lease agreement at the time the agreement was made. Petitioner sought review of the hearing officer's decision by a HCFA review officer. That officer affirmed the decision. Pet. App. 5a.

Petitioner then sought judicial review of the Secretary's final decision in the district court. Pet. App. 27a, 31a. It contended that application of the related party rule violated the Administrative Procedure Act, 5 U.S.C. 551-559, 701-706, the Medicare Act, and the Due Process Clause. Petitioner asserted that the court had jurisdiction under 28 U.S.C. 1331, 28 U.S.C. 1346, and 42 U.S.C. 1395*oo*(f)(1). Pet. App. 6a & n.4.

The district court granted the Secretary's motion to dismiss the action for lack of subject matter jurisdiction. The court held that it lacked jurisdiction under 42 U.S.C. 1395*oo* because petitioner did not meet the $10,000 amount-in-controversy requirement. The court also held that 42 U.S.C. 1395ii, which incorporates the preclusions of review in 42 U.S.C.

405(h), bars suit under 28 U.S.C. 1331 or 1346. Pet. App. 10a-14a.

3. The court of appeals affirmed. Pet. App. 2a-9a. The court of appeals agreed with the district court that petitioner did not satisfy the amount-in-controversy requirement for suit under 42 U.S.C. 1395*oo*, and that 42 U.S.C. 1395ii expressly barred petitioner's suit under 28 U.S.C. 1331 and 1346. The court rejected petitioner's argument that this Court's decision in *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), requires that petitioner be able to obtain judicial review under 28 U.S.C. 1331. The court explained that *Michigan Academy* recognized a limited exception to the strict rule of 42 U.S.C. 1395ii only where Congress has provided no other avenue of judicial review. In this case, Congress expressly provided an avenue for judicial review under 42 U.S.C. 1395*oo*(f)(1), but precluded review of claims where the amount in controversy is less than $10,000. Consequently, the court held, petitioner could obtain judicial review only by meeting the requirements established by Congress, including the amount-in-controversy requirement. Pet. App. 6a-9a.

ARGUMENT

1. The lower federal courts have only such jurisdiction as Congress confers upon them by statute. *Christianson* v. *Colt Industries Operating Corp.*, 486 U.S. 800, 818 (1988); *Sheldon* v. *Sill*, 49 U.S. (8 How.) 441, 449 (1850). No statute confers jurisdiction on the district court in this case.

The district court plainly lacked jurisdiction under 42 U.S.C. 1395*oo*. That Section provides for judicial review of HHS provider reimbursement decisions only if the amount in controversy is at least $10,000,

or if a group of providers has aggregate claims of at least $50,000. Since petitioner's claim is for less than $10,000, jurisdiction cannot be based on Section 1395*oo*.

Nor is there jurisdiction under 28 U.S.C. 1331 or 1346. Jurisdiction under those Sections is expressly barred by 42 U.S.C. 1395ii, which incorporates by reference the provisions of 42 U.S.C. 405(h). Section 405(h), in turn, provides:

> The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

Section 1395ii reflects Congress's clear intention to preclude judicial review of claims arising under the Medicare Act, except as provided in Section 1395*oo*. This intention is manifested by both the second and the third sentences of 42 U.S.C. 405(h), as incorporated by 42 U.S.C. 1395ii.

In its complaint, petitioner specifically sought review of the "final administrative decision of the Secretary," rendered through HCFA, on its claim for reimbursement under its cost report for 1984. Pet. App. 27a, 31a. The second sentence of Section 405(h) provides, however, that no "decision of the Secretary shall be reviewed by any * * * tribunal * * * except as herein provided"—i.e., except as provided in the Social Security Act itself. As we have explained, the Medicare title of the Social Security Act "provide[s]"

for judicial review in a case such as this only where the amount in controversy is $10,000 or more. Because that requirement is not met here, the "decision of the Secretary" that petitioner challenges is not subject to review in the "tribunal" whose jurisdiction it invoked—the federal district court.

The third sentence of 42 U.S.C. 405(h) likewise bars this suit. Petitioner is claiming a right to be reimbursed for certain rental expenses under the Medicare Act. That is plainly a claim "arising under" the Act. See *Heckler* v. *Ringer*, 466 U.S. 602, 615 (1984); *Weinberger* v. *Salfi*, 422 U.S. 749, 760-761 (1975). Accordingly, the third sentence of Section 405(h) bars petitioner from bringing an action under 28 U.S.C. 1331 or 1346.

2. Petitioner argues that, under this Court's decision in *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), the district court had jurisdiction under 28 U.S.C. 1331. Petitioner misreads *Michigan Academy*. That case concerned a challenge to a regulation governing the amount payable under Part B of the Medicare program. At the time the case was decided, Congress had provided no forum in which to challenge amount determinations on claims for benefits under Part B.[4] In allowing a challenge to the regulation to proceed under 28 U.S.C. 1331, the Court relied on the fact that, if there were no jurisdiction under Section 1331, there would be *no* forum, administrative or judicial, in which such a challenge could be brought. See 476 U.S. at 680 (rejecting the "assumption that Congress contemplated

[4] Congress has since amended the statute to provide for judicial review of administrative decisions on Part B claims, subject to an amount-in-controversy requirement of $1,000. See 42 U.S.C. 1395ff(b)(1)(C) and (b)(2).

review by [carriers] of 'trivial' monetary claims, * * * but intended no review at all of substantial statutory and constitutional challenges to the Secretary's administration of Part B of the Medicare program.").

This case is quite different. Congress has expressly created both an administrative and a judicial forum in which a provider of services may challenge a reimbursement decision under Part A, including a challenge to the regulations and instructions that the intermediary and the Secretary followed in reaching their decision. Congress has, however, limited access to these forums by imposing an amount-in-controversy requirement in 42 U.S.C. 1395*oo* and by foreclosing other avenues of review in 42 U.S.C. 405(h). When Congress expressly creates a forum for judicial review of agency action, a plaintiff must meet the requirements that Congress establishes for access to that forum. Accordingly, a district court is not free to disregard the amount-in-controversy requirement that Congress has established as a prerequisite for judicial review in a case such as this. See generally *Block* v. *Community Nutrition Institute*, 467 U.S. 340, 348 (1984) (upholding limitations on judicial review where absence of restrictions "would severely disrupt * * * complex and delicate administrative scheme").

This case is governed, not by *Michigan Academy*, but by *Heckler* v. *Ringer*, 466 U.S. 602 (1984). In that case, an individual who was eligible for Medicare benefits wished to have an operation known as a bilateral carotid body resection (BCBR) to relieve his suffering from respiratory distress. The Secretary, acting through HCFA, had issued an instruction that no payment was to be made for such surgery. Ringer and other plaintiffs brought suit challenging the Secretary's instruction on various constitutional and

statutory grounds, including denial of due process of law. The plaintiffs alleged jurisdiction under 28 U.S.C. 1331.

This Court held that the federal courts had no jurisdiction over the plaintiffs' claims because the plaintiffs had not exhausted their administrative remedies. The Court noted that, under Part A of the Medicare Act, plaintiff Ringer would be entitled to judicial review of his constitutional and statutory claims if he had the BCBR surgery, submitted a claim for payment to the Secretary, and ultimately had the claim administratively rejected after exhaustion of his administrative appeals. *Ringer*, 466 U.S. at 606-607. The Court held that 42 U.S.C. 1395ii (which makes 42 U.S.C. 405(h) applicable to the Medicare Act) barred the plaintiffs from seeking judicial review of their claims by any route other than the one expressly provided by Congress. 466 U.S. at 614-615, 622-623.

Ringer directly supports the court of appeals' decision in this case. It holds that where Congress has created an exclusive avenue for judicial review of constitutional and statutory challenges to Medicare rules and regulations, but has also established requirements that limit access to that forum, plaintiffs may obtain judicial review only if they meet those requirements. See also *Weinberger* v. *Salfi*, 422 U.S. 749, 762 (1975) ("[T]he plain words of the third sentence of § 405(h) do not preclude constitutional challenges. They simply require that they be brought under jurisdictional grants contained in the Act."). Here, petitioner does not meet the amount-in-controversy requirement by which Congress has limited access to the forum it has created for judicial review of provider reimbursement decisions. Accordingly,

the court of appeals correctly held that the district court had no jurisdiction over this case.

3. Petitioner contends that the court of appeals' decision conflicts with *Beverly Hospital* v. *Bowen*, 872 F.2d 483 (D.C. Cir. 1989). But in *Beverly Hospital* the court held, in the unique circumstances of that case, that there was no way any provider could have challenged the Secretary's actions in a proceeding under 42 U.S.C. 1395*oo*. 872 F.2d at 486. Accordingly, the court held that there was no expressly created forum for judicial review of the Secretary's actions. In the present case, in contrast, there is a judicial forum in which providers can challenge the Secretary's rule; petitioner simply does not meet the amount-in-controversy requirement for access to that forum. Thus, there is no conflict between this case and *Beverly Hospital*.

We note that the court of appeals' decision in this case is in some tension with *Bartlett* v. *Bowen*, 816 F.2d 695 (D.C. Cir.), reh'g order vacated, 824 F.2d 1240 (D.C. Cir. 1987), a decision that petitioner does not cite. In that case, the plaintiff's decedent filed a Part A Medicare claim in the amount of $286, which was denied. The plaintiff claimed that the denial had violated her decedent's First Amendment right freely to exercise her religion (because it was based in part on her use of a Christian Science facility). Even though the Medicare Act limits judicial review of individual Part A claims to those cases where the amount in controversy is at least $1,000, see 42 U.S.C. 1395ff (b)(2)(A), the D.C. Circuit held that, because of the constitutional nature of the plaintiff's claim, the district court had jurisdiction.

There is no occasion to grant certiorari here to resolve any tension between this case and *Bartlett*. First, petitioner does not even cite *Bartlett* in its

petition for a writ of certiorari. Indeed, petitioner expressly disclaimed reliance on that decision in the court of appeals. See Pet. C.A. Reply Br. 12-13 (*Bartlett* "has no applicability to Appellant's appeal"). Second, *Bartlett* did not involve 42 U.S.C. 1395*oo*, but instead concerned 42 U.S.C. 1395ff(b), a different provision of the Medicare Act that applies to individuals rather than providers of services. (The difference may be significant because providers of services agree to participate in Part A of the Medicare program, while individuals have no choice whether to pay Medicare taxes and are automatically enrolled.) Third, six judges of the D.C. Circuit indicated that they believed the decision in *Bartlett* to be highly doubtful or incorrect. See 824 F.2d at 1247 (Silberman, J., concurring in the denial of rehearing en banc) ("[W]ere I forced to choose, I would be inclined to favor the dissent's analysis."); *id.* at 1247-1248 (Bork, Starr, Buckley, Williams, & D.H. Ginsburg, JJ., dissenting from the denial of rehearing en banc) (panel's decision is "clearly wrong," or "at the very least, highly dubious."). And as Judge Silberman observed (*id.* at 1247), the panel's remarks on the constitutional issues were dicta that will not bind the D.C. Circuit in future cases. Hence, it is entirely possible that the D.C. Circuit will revisit and modify *Bartlett*.

Finally, the plaintiff in *Bartlett* "raised a serious challenge to the constitutionality of the Medicare Act on its face." 816 F.2d at 701. In contrast, petitioner's constitutional claim—which concerns only an administrative instruction and not the Act itself— appears to be frivolous. There is simply no serious argument that the Constitution prevents the Secretary from including in the Provider Reimbursement Manual a section stating that if a provider and a supplier are related by common ownership or control at the time a

contract is signed, the contract will be treated as if the provider and supplier remained subject to common ownership or control for the life of the contract. Nor is there any plausible constitutional argument that such a provision must be adopted through a rule-making proceeding under the APA, or that such a provision (which follows directly from the related-party principle set out in 42 C.F.R. 405.427 (1984)) may not be applied to contracts in existence when it was issued.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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